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HEALTH CARE NEWS

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Canadian Pharmacies Flunk Inspections

by Conrad F. Meier

The number of U.S. politicians who have reversed course and now publicly endorse the importation of prescription drugs from Canada would seem to reflect newly found evidence that drugs imported from Canada are safe. But that is not the case. Indeed, new evidence points to the danger of expanding importation.

Agence France Presse

Canadian and American flags sit in the foreground as Canadian pharmacist Amanda Hutchinson (L) hands fellow pharmacist Florence Ticne (R) the prescription drugs for a group of Minnesota senior citizens.

Importing Trouble

In a memorandum dated December 24, 2003, Minnesota's Board of Pharmacy details the findings of a board-approved evaluation trip made by Cody Wiberg, pharmacy program manager for the Minnesota Department of Human Services, and two pharmacy board surveyors.

The purpose of the trip was to evaluate Canadian pharmacies for possible affiliation with Republican Governor Tim Pawlenty's new State of Minnesota prescription drug Web site. The board evaluated eight pharmacies in Toronto, Winnipeg, Calgary, and Vancouver.

The December memo states, "We found significant differences in pharmacy practices between those owned primarily by pharmacists and those owned by non-pharmacist business partners." Several of

FLUNK continued on page 8

Congress Takes Up Health Policy Measures

by Tom Bruderle

Following the 2003 enactment of tax-preferred health savings accounts, President George W. Bush recommended in this year's State of the Union address that Congress make tax-deductible the premiums paid for catastrophic health insurance policies tied to health savings accounts (HSAs).

Rep. Bill Thomas (R-California), chair of the House Ways & Means Committee, supports the President's proposal. He said deductibility would lead to a "more level playing field" between the group health insurance market, with its tax breaks for employers, and the individual market, where those tax benefits do not exist.

Democrats oppose the deductibility of catastrophic health insurance premiums, as they opposed HSAs in last year's Medicare debates. They contend anything that makes HSA policies attractive would hurt the group insurance market and reduce public support for new efforts to

CONGRESS continued on page 4

Maine Tries "Voluntary" Socialized Health Care

by Conrad F. Meier

While the most dramatic—and widely popular—trend in health care today is toward patient control over health care decision-making, state government officials in Maine appear determined to take their constituents down a path toward socialized medicine that few have tried and none has successfully navigated.

This summer, the state will begin enrolling residents in its health care pro-

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Clinton-Style Task Force Resurfaces

by Sue Blevins

Tucked away at the back of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is a provision reminiscent of the oft-criticized health care working group headed by former First Lady Hillary Clinton. It appears to provide taxpayer financing for an advocacy group committed to universal health care in the United States.

The provision—titled "Health Care That Works for All Americans: Citizens' Health Care Working Group (HCWG)"—will cost taxpayers $3 million a year during fiscal years 2005 and 2006.

Stated Purposes

The purpose of the HCWG is "to provide for a nationwide public debate about improving the health care system to provide every American with the ability to obtain quality, affordable health care coverage." The HCWG is charged with holding hearings, sponsoring community meetings, making recommendations, and

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Congress

Continued from page 1

nationalize and regulate health care.

House Republicans have the votes to prevail on the deductibility issue, but the matter is far less certain in the Senate, where the Republican leadership would need 60 votes to counter an expected Democratic filibuster.

AHPs Stalled

Prospects for the enactment of association health plan legislation in the Senate remain dim. In June 2003, the House approved HR 660—the Small Business Health Fairness Act of 2003—permitting small businesses to join with one another to purchase health insurance coverage for their employees under uniform federal regulation by the Department of Labor, thus avoiding state oversight.

A companion Senate bill, S 545, cosponsored by Senators Olympia Snowe (R-Maine) and Kit Bond and James Talent (R-Missouri), has attracted little interest from Senator Judd Gregg (R-New Hampshire), chair of the Health, Education, Labor and Pension committee, which has jurisdiction.

Without commenting on the bill, Majority Leader Bill Frist (R-Tennessee) has said on several occasions he would defer to Gregg and his committee for action.

The ranking Democrat on Gregg's committee, Senator Ted Kennedy (D-Massachusetts), opposes AHPs. "Those

Rep. Bill Thomas (R-California)

"Prospects for the enactment of association health plan legislation in the Senate remain dim."

plans are nothing more than giveaways to Republican trade associations and will raise the premiums for more than 20 million workers," he has said. A Kennedy spokesman was even more to the point, saying simply, "AHPs will never get through the Senate."

Kennedy Proposes Play-or-Pay

Kennedy prefers employer mandates. Under his "Health and Insurance Affordability Act," employers with at least 50 workers would be required to provide health insurance to their employees, with the federal government paying any costs that exceed 12 percent of the employer's payroll.

Employers with between five and 50 workers would be required either to offer health coverage or contribute to a government program providing coverage, modeled after the Federal Employees Health Benefits Program (FEHBP). Employers with five or fewer workers would be exempt from the mandate but allowed to participate in the federal program if they chose to do so.

Most large employers and profitable smaller businesses would pay about 75 percent of the cost of their employees' health insurance plans under the Kennedy proposal, while the federal government would pay the remainder, estimated at $100 billion annually.

The bill also contains incentives to boost health care quality, promote information technology advancements, permit drug importation from European Union countries and Canada, limit direct-to-consumer advertising by pharmaceutical manufacturers, and allow the Department of Health and Human Services to negotiate drug prices on behalf of Medicare beneficiaries. The bill's chances in a Republican-controlled Congress are slim.

Looking Ahead

The outlook for congressional action this session on these and other health issues is murky.

The House is sharply divided along partisan lines on these measures. The environment is often described, by members and staffers alike, as "poisonous." While some committees function cooperatively, and some member-to-member relations across party lines are strong, party rancor is the rule, not the exception. There is a great deal of resentment among some Republicans over the mounting federal deficit and the recently enacted Medicare reform legislation, whose cost is now at least $145 billion more than Congress was led to believe.

In the Senate, the Republican majority would require 60 votes to silence any Democratic filibuster and bring an issue to a vote. While a simple majority vote then would prevail, even that is problematic due to the shifting nature of alliances among conservative, moderate, and liberal/progressive Democrats and Republicans. For Frist, it can be an unceasing struggle within his own ranks and House colleagues, not to mention Democrats.

Compounding these atmospherics is the limited schedule remaining for this session of Congress. Both parties have Presidential nominating conventions this summer— the Democrats the last week of July, the Republicans a month later—along with an "August recess" that begins the third week of July.

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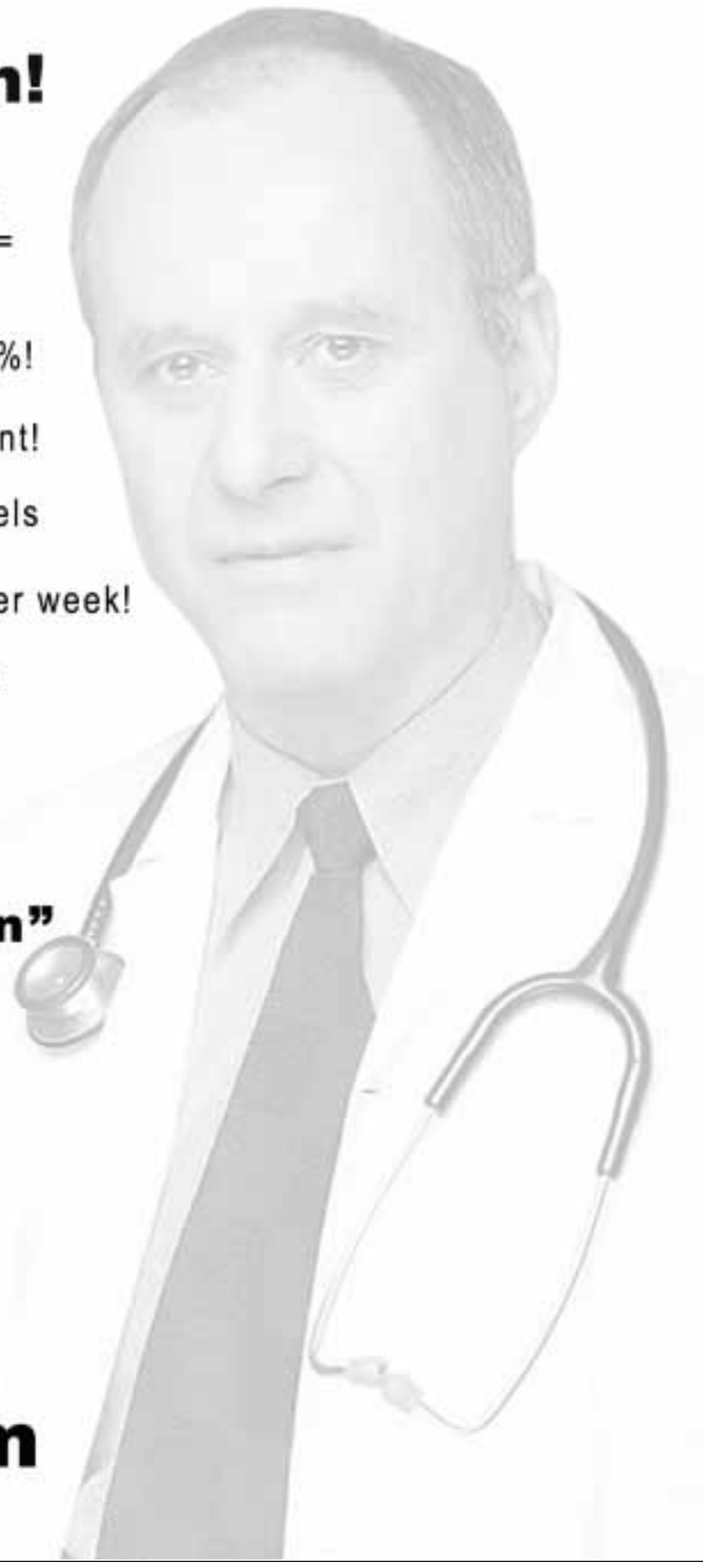

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Task Force

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publishing a national report.

The HCWG is also supposed to "provide for a vote by Congress on the recommendations that result from the debate." In other words, the HCWG, using tax dollars, will stir debate about universal health care, and then Congress will be pressured to vote on it.

Process and Timeline

The HCWG is required to hold hearings within 90 days of the appointment of its chairperson. Within 90 days of the completion of hearings, the group is to publish a report titled "The Health Report to the American People." The report must include a summary of:

- health care services used by individuals;
- cost and effectiveness of health care services for different age groups;
- source of coverage and payment for health services;
- reasons people are uninsured or underinsured;
- health care outcomes and costs of treating diseases; and
- health care cost containment strategies.

"The … Citizens' Health Care Working Group (HCWG) will cost taxpayers $3 million a year during fiscal years 2005 and 2006."

The HCWG also is required to "prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings."

The public then has 90 days to submit comments. Within 120 days of the end of the comment period, the HCWG must submit to the President and Congress a final set of recommendations. The HCWG differs from the Clinton health care task force in that it will include ordinary citizens' input and has bipartisan support.

Within 45 days of receiving final recommendations from the HCWG, the President is required to submit a report to Congress containing "additional views and comments on such recommendations; and recommendations for such legislation and administrative actions as the President considers appropriate."

Then, within 45 days of receiving the report submitted by the President, each of the following congressional committees is required to hold at least one hearing on the HCWG's report and its final recommendations:

- House Ways and Means Committee
- House Committee on Energy and Commerce
- House Committee on Education and the Workforce
- Senate Finance Committee
- Senate Committee on Health, Education, Labor, and Pensions.

HIPAA Strategy

It is worth noting the law creating the HCWG looks somewhat like the strategy used to create the so-called federal medical privacy regulations, which actually authorized more than 600,000 entities to see Americans' medical records without their consent. Those regulations were added to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at a time when most people were focused on the medical savings account debate.

The privacy provision required Health and Human Services (HHS) to submit to Congress recommendations regarding medical privacy. Congress and HHS held hearings on medical privacy, but most of the hearings were stacked in favor of groups wanting greater access to patients' medical records. HHS essentially ignored thousands of public comments when revising the final federal rule.

Policy Questions

The Clinton administration's health care task force was widely criticized, and eventually sued, for operating behind closed doors. The Bush administration's HCWG process appears likely to be more transparent. The supporters of patient-driven health care can take some comfort in that promise.

Although not specified in the HCWG's mandate, two policy questions will be critical for the group to address:

- Who should dictate patients' health care choices: the government, health care professionals, or individuals themselves?
- Should Americans be forced to use taxpayer-financed health care, even if they choose and can afford to pay privately for health insurance and services?

Sue Blevins is founder and president of the Institute for Health Freedom in Washington, DC. Her email address is **Feedback@ForHealthFreedom.org**.

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Flunk

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the pharmacies visited were termed "... the 'Super 6' and were among the first pharmacies in Canada to begin the Internet practice of selling Canadian prescription drugs to U.S. customers."

All but one of the pharmacies visited was a member of the Canadian International Pharmacy Association (CIPA). But even among the CIPA member pharmacies, the Minnesota team found quality standards varied greatly from pharmacy to pharmacy; some CIPA members appeared to have no standards at all.

In Harm's Way

The team of evaluators said its visits were not inspections, since they had no legal authority to conduct inspections. They visited the pharmacies by invitation. In many cases, they were shown only limited information and were not allowed to move freely about the premises. While the memo cites numerous examples of conditions the evaluators deemed "poor pharmacy practices," not all are reported here. The full report is now a matter of public record and online at **www.phcybrd.state.mn.us/canada_memo.pdf**.

- One pharmacy was not labeling most dispensed drugs. Instead, the labels were shipped unattached in the same shipping container as the stock medicine containers. This took place even when patients were being shipped multiple medications.
- In one pharmacy, unsupervised technicians were working in several different buildings "at a technician to pharmacist ratio that far exceeded the allowable technician ratio in Minnesota."
- In another pharmacy visited, "an unsupervised technician appeared to be responsible for contacting the American prescriber by telephone if something on the original prescription needed to be clarified. This is a task that a pharmacy technician would not be allowed to perform under Minnesota pharmacy laws and rules, even if pharmacist supervision were present."
- One pharmacy had no procedures in place to handle drug recalls. When the evaluators asked about this they were told, "The patient could contact the pharmacy about a recall if they wished."
- An incomplete patient profile was kept at many of the pharmacies. One pharmacy did not require drug allergy information to be obtained and other patient profiles were incomplete. According to the Minnesota Pharmacy Board report, "This is poor pharmacy practice at best and very dangerous at worst."
- A Quality Assurance check is required of all Minnesota pharmacies. Two pharmacists must review all new prescriptions to verify the accuracy of the computer-generated prescription. The Minnesota team reported this quality control procedure appeared to be taking place at only one of the eight Canadian pharmacies visited.

"One [Canadian] pharmacy required customers to sign a patient disclaimer that waives any and all liability in case of harm resulting from adverse effects or death as a result of purchasing across-border drugs."

- One pharmacy had on its shelves filled medication containers with remnants of removed pharmacy prescription labels. The report states, "When we inquired about this practice we were told that these were products returned from Customs. The pharmacy owner, a non-pharmacist, stated that as long as the patient had not received the product they could continue to use them."
- About half of the prescriptions filled by one Canadian pharmacy went to a single pharmacy in San Francisco, which had sent the prescriptions to pharmacies in England to be filled and shipped to U.S. consumers.
- One pharmacy required customers to sign a patient disclaimer that waives any and all liability in case of harm resulting from adverse effects or death as a result of purchasing across-border drugs.

Reasonable Doubt

The Minnesota group admits its findings represent an incomplete picture of Canadian pharmacy practices, and it acknowledges some of the practices observed were actually better than the standard employed by some Minnesota pharmacies.

The board concluded its report saying, "If laws were such that licensing Canadian pharmacies would be a possibility and if Minnesota Board of Pharmacy surveyors were able to make unannounced inspection visits, some of these Canadian pharmacies should be as good as or better than the U.S. mail order pharmacies that we currently license."

The report nevertheless raises the level of doubt surrounding the quality and safety of importing and reimporting prescription drugs across borders, whether from Canada, the European Union, or the Far East. Only 60 percent of the Canadian drug supply is initially purchased from the United States. That leaves 40 percent of the Canadian drug supply coming from unknown sources.

As the co-founder and president of one the pharmacies visited told the Minnesota evaluators, "We won't have any problem getting drugs, we have creative ways to get them."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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Canadian Health Care System Nears Collapse

by Conrad F. Meier

In no-nonsense language cutting across their diverse political stripes, Canadian provincial premiers lashed out at the federal government for reducing its share of provincial health care budgets at a time when costs are rising 10 percent a year.

The premiers met in February 2004 in a special session to discuss the state of health care in Canada. On March 8, the premiers of all 13 provinces and territories launched a national advertising campaign to air their concerns.

Prince Edward Island Premier Pat Binns warned, "our current system is not sustainable, the principles of the Canada Health Act are at risk, and health care as we know it will not survive the end of the decade."

Alberta Premier Ralph Klein made clear his province's willingness to consider opting out of the Canada Health Act, the single-payer enabling legislation also known as medicare.

"If Ottawa refuses to negotiate significant changes to medicare, we are willing to consider, as a province, going it alone. We are still a long way from that, but it is a consideration," Klein said.

According to many reports in the Canadian press, no other premier went as far as Klein. "If the richest province in Canada feels that the system may not be sustainable as it is, you can just imagine what it means for the rest of us," noted New Brunswick Premier Bernard Lord. That "walking away" from the Canada Health Act was even discussed indicates the gravity of the situation, according to Saskatchewan Premier Lorne Calvert.

Show Me the Money

The premiers say they need sustainable funding for health care from the federal government, not more one-shot deals like the $2 billion Ottawa recently promised. Premiers want the federal government to boost its share of health care funding from the current level of 16 percent to 25 percent.

The premiers also were irate over the expanding federal surplus, now estimated at between $5 billion and $8 billion. When they met in late February with Prime Minister Paul Martin and accepted the $2 billion federal injection of health care money, premiers were told the surplus was barely over the $2 billion mark. Finance Minister Ralph Goodale refused to commit the government to more health spending.

"What a tragedy for Canada, where we have a federal government sitting on surpluses and then to also have a system where medicare falls apart," commented Manitoba Premier Gary Doer.

But not all observers of the Canadian health care situation agree more money is needed. Sally Pipes, a former Canadian citizen who is president of the San Francisco-based Pacific Research Institute for Public Policy, told *Health Care News*, "The problems with the Canadian health care system will not be solved by more revenue. Canadians are already taxed to death.

Alberta Premier Ralph Klein listens to questions following the Provincial Premiers and Territorial Leaders meeting in Vancouver February 24, 2004.

Reuters

"The solution to the dilemma lies in opening up the Canadian system to competition," said Pipes. "Less government, not more, is the answer to long waiting lines, lack of the latest technological equipment, and rationed care."

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

INTERNET INFO

For more information on the advertising campaign launched in March by the provincial premiers, visit the Web site of the Premiers' Council on Canadian Health Awareness at **http://www.premiersforhealth.ca/communicate.php#ads**.

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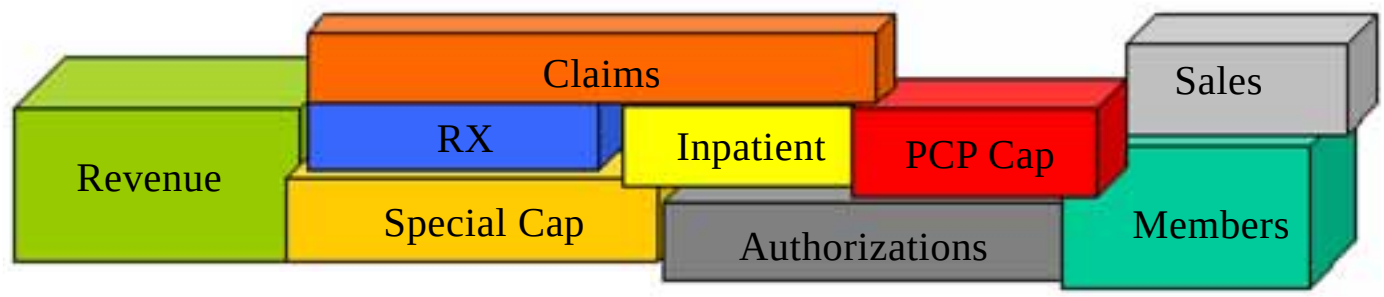

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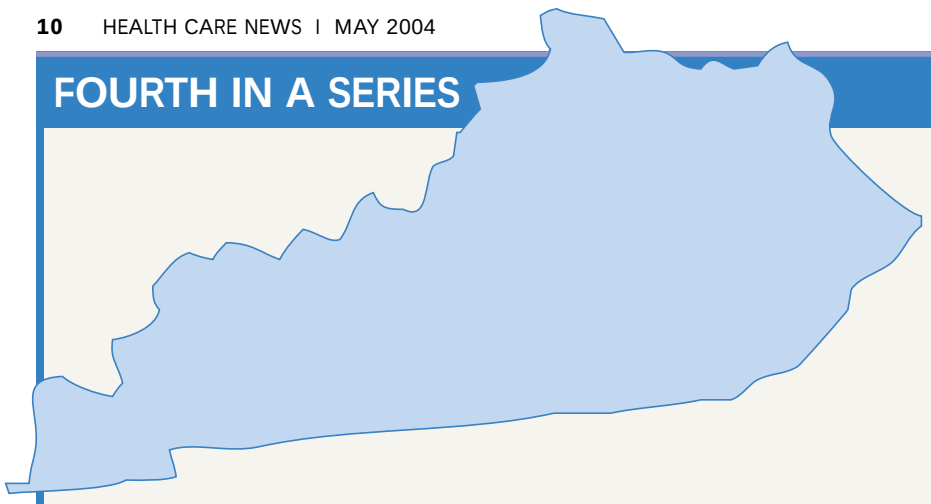

Kentucky Governor Fletcher Seeks Insurance Reform

Free-market health insurance makes slow come-back

Kentucky Governor Ernie Fletcher

by Conrad F. Meier

On March 24, Kentucky Governor Ernie Fletcher was handed HB 650, legislation aimed at resuscitating a health insurance market that has suffered greatly from a decade of state government interference.

As this issue of *Health Care News* went to press, the governor was expected to sign the measure but had not yet done so.

The bill, titled simply "an act relating to Health Benefit Plans," passed the House of Representative on a 95-2 vote and the Senate by 35-1 in March. The measure will

- ban for three years all new state mandates requiring health insurers to cover specific medical conditions and treatments;
- eliminate regulations that require all insurers to offer standard benefit plans; and
- reduce bureaucratic paperwork and insurance rules to make them comparable to other states that compete with Kentucky.

Observers hope the new law will encourage the return of many insurers who left the state since 1994. Presently, only Anthem Blue Cross/Blue Shield, Humana, Fortis, John Alden, Mega Life and Health Insurance Company, and Physicians Mutual operate in Kentucky.

Unintended Consequences

In 1994—with the nation still abuzz over the Clinton administration's 1993 proposal to nationalize the country's health care system—the Kentucky legislature passed sweeping measures policymakers believed would make health insurance more affordable, and health care more accessible, for the state's residents.

The key provisions of the reform measure, HB 250, included modified community rating and guaranteed-issue mandates on insurers; a risk-adjustment process among insurers that favored Blue Cross Blue Shield (BCBS); and five standard benefit plans that differed relatively little with respect to deductible, co-pay level, etc. The benefit plans could not be amended until July 1995.

Policymakers also mandated the establishment of a statewide health purchasing alliance, known as Kentucky Kare. To ensure the plan's financial viability, policymakers required all state government employees to join. Kentucky Kare also served as the "insurer of last resort" for the uninsured not eligible for Medicaid.

The mandates were imposed on top of an existing, complex system of consumer safeguards that included federal government requirements under the Consolidated Omnibus Budget Reconciliation Act (COBRA), mini-COBRA, benefit mandates, underwriting mandates, and financial reserve requirements. Little attention was paid, by state legislators or activists lobbying for the new mandates, to potential interactions between regulations old and new.

The combination of modified community rating, guaranteed issue, mandated benefit packages, and patient access laws created contradictory and counter-productive incentives that hurt consumers, insurance companies, and health care providers alike.

A 1996 law freezing premiums in the individual and small group markets at pre-reform rates made the mess even worse, while hiding the mounting problems from the general public. Healthy Kentuckians generally sought out policies with premium rates frozen at lower levels, while the unhealthy population was forced to choose between more expensive community-rated plans, Kentucky Kare, or Medicaid.

"The combination of modified community rating, guaranteed issue, mandated benefit packages, and patient access laws created contradictory and counter-productive incentives that hurt consumers, insurance companies, and health care providers alike."

Insurance Market in Turmoil

The new insurance industry regulations favoring BCBS and the mandate making government employees captive to Kentucky Kare had a devastating impact on the state's private individual and small group health insurance market. In April 1997, the Kentucky Department of Insurance reported:

- by December 1996, 45 insurance companies had pulled out from the state's individual insurance market. Insurance Commissioner George Nichols told the *Louisville Courier-Journal* the state was "moving toward a crisis."
- Anthem BCBS—for years the state's largest insurer in the individual market and by 1996 virtually the only insurer in the market—reported an underwriting loss of $60 million;
- Kentucky Kare reported a $30 million underwriting loss over the previous 20 months and increased premiums 28 percent for 1996.

Premium Increases

As competition in Kentucky's individual insurance market fell and remaining insurers offered benefit packages mandated by the state, Kentuckians got a rude awakening. Out-of-pocket expenses rose above what they had been in pre-reform days and average premiums jumped between 36 and 165 percent.

Donald Harden, a Florence insurance agent and president of the Northern Kentucky Association of Life Underwriters, reported at the time that one of his customers had been paying $380 a month for a family plan in the private insurance market. After the legislature's 1994 actions, Harden's client had to buy into the Kentucky Kare plan ... for a monthly premium of $700, with reduced benefits.

Reported the *Courier-Journal* on October 17, 1997, "Gail Collins, a self-employed food distributor in Louisville, said she had individual insurance but didn't think she should have to pay inflated premiums for the unhealthy.

"Steve Carter, owner of the 4th Avenue Deli, also in Louisville, is

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healthy but can't afford to buy insurance for himself and his seven employees," the *Courier-Journal* continued.

All told, some 850,000 Kentuckians faced dramatically higher premium payments after the 1994 reforms.

Increase in Uninsured Population

U.S. Census Bureau data suggest the Kentucky reforms may have resulted in an *increase* in the share of the state's population that was uninsured. In 1993, the year before the reform measure was passed, 12.5 percent of the state's population was uninsured. By 1996, that figure had reached 15.6 percent. It has since fallen again, to 13.6 percent in 2002 (the most recent year for which data are available)—still higher than the pre-reform figure.

Fully 548,000 Kentuckians were without health insurance in 2002—a 17.1 percent increase over the 468,000 uninsured in 1993. By contrast, the number of people in the United States who were uninsured increased just 9.7 percent between 1993 and 2002.

In 1993, the pre-reform year, 14.1 percent of Kentucky's population was insured in the individual market, higher than the national average of 13.1 percent. By 2001, the national average had fallen to 8.3 percent … but in Kentucky, it fell even further. Just 6.9 percent of the state's population was insured in the individual market in 2001. (See accompanying figure.)

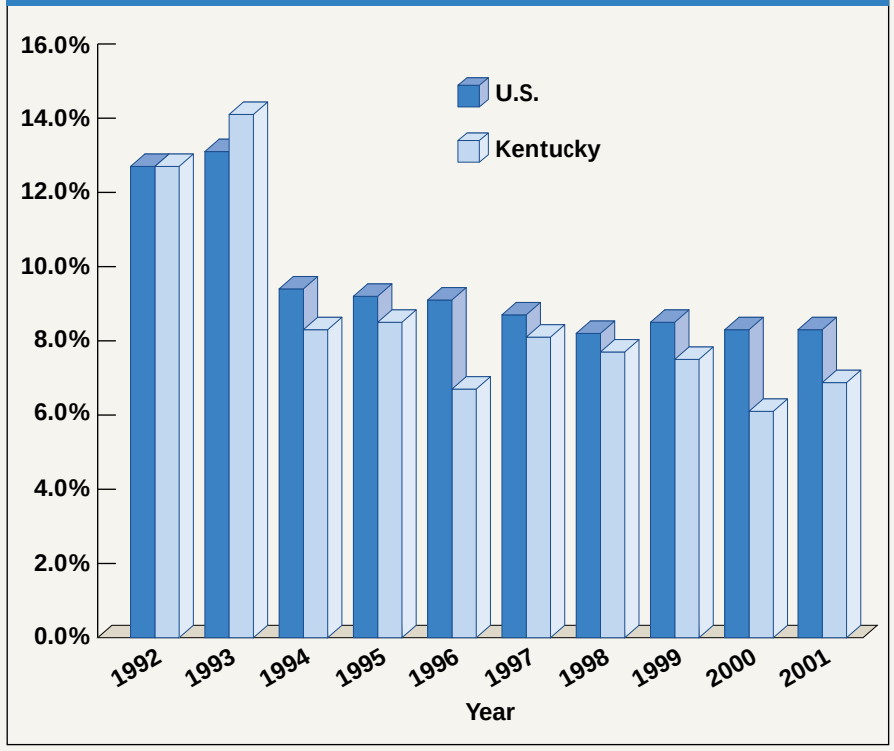
As Bob Rich, an independent insurance broker from Florence, told the *Kentucky Post* in April 1997, "The system was working for 95 percent of the people. We basically destroyed a system that works to satisfy the other 5 percent."

Not all Kentuckians agreed. In October 1997, a spokesperson for the Kentuckians for Health Care Coalition—an advocacy group that had lobbied hard for the 1994 legislation—told the *Courier-Journal*, "many Kentuckians with high-cost conditions today enjoy having insurance for the first time."

Reforming the Reforms

In 1996, the legislature halfheartedly acknowledged the 1994 reforms weren't achieving the intended result. Realizing the state had become a magnet for unhealthy people from other states, policymakers imposed a one-year residency requirement for enrollment in Kentucky Kare. Other reforms allowed private insurance companies to exclude coverage of pre-existing conditions for 12 months, and the band of rates private insurers could charge was widened. Such "tweaking" notwithstanding, guaranteed issue and community rating mandates were left mainly intact.

Percent of Population with Individual Health Insurance
Kentucky and U.S. Average



In 1997, a special session of the legislature was called to deal further with health insurance matters. The most notable result of the session was a 50 percent rate increase for the state's near-monopolist private insurer, Anthem BCBS, pushing premiums to historic highs.

In 1998, legislators passed HB 315, a disastrously complicated attempt at reforming the reform. Insurers were still required to guaranteed issue a standard plan along with their two most popular plans. More rating flexibility was approved and a streamlined rate review mechanism was put in place, but insurers were required to obtain state officials' approval of their underwriting practices. A complicated risk-spreading system was approved, as was a "play or pay" measure similar to one that had been rejected during 1997's special session.

By the end of the year, Kentucky Kare was being accused of "gross mismanagement" by the state auditor and the *Lexington Herald-Leader*. BCBS was saying it needed to raise rates an average of 52 percent because, reported the *Herald-Leader*, it was paying out $1.30 for every $1.00 it was taking in.

> **"The fact that the state has 'reformed' health insurance every two years since the original reform in 1994 has created a climate which is not conducive for getting objective data about the right course of action for guiding the state out of the morass."**

The legislature was not in session in 1999. No insurers had returned to the state, lending strength to an ultimately successful effort toward reform in 2000. HB 517, signed by the governor in April that year, took these positive steps (among others):

- established a high-risk pool;
- eliminated the guaranteed-issue mandate; and
- broadened the rate band, although keeping community rating in place.

The measure was not perfect, leaving in place certain regulations that ensured the state's climate for insurance carriers would remain less hospitable than other states. The five insurers that returned are a small share of the original 45 that once made up a vibrant and competitive insurance marketplace.

What the Future Holds

Rod Turner, vice president of American Republic Insurance—which pulled out of the Kentucky market in 1995—explained why the passage of legislation may not be enough to undo the damage done by the legislature in 1994. He told Patrick Howington, business editor of the *Courier-Journal*, "It may not be in our business plan, we may not have a distribution system there—there may be a lot of reasons why we would or would not go back."

Golden Rule Insurance Company, now owned by UnitedHealth Group, told the *Courier-Journal* Kentucky "has come a long way to restoring a market that is viable." While the company is weighing a decision to return, others will never return, as regulations adopted in Kentucky and elsewhere forced them out of the business of writing health insurance policies entirely.

"Kentucky's health insurance market is recovering from legislative changes made in 1994 and 1996 that inadvertently set the stage for declining competition, higher costs, and general insurance market instability," summarizes the Kentucky Chamber of Commerce in its 2003-04 Policy Document on health care.

Nevertheless, the Chamber continues, "the fact that the state has 'reformed' health insurance every two years since the original reform in 1994 has created a climate which is not conducive for getting objective data about the right course of action for guiding the state out of the morass."

The measure on Governor Fletcher's desk—by banning new mandated benefits, freeing insurers from the standard benefit plan requirement, and cutting red tape and paperwork—should make it easier for insurers to return to the state.

Consumers, policy wonks, and insurance industry analysts will be watching closely. Kentucky may be on its way back from the abyss.

Next month: Washington State

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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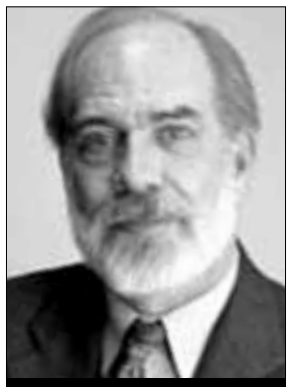
Greg Scandlen

Commonwealth Fund Distorts Employer Attitudes

The reported findings of the latest Commonwealth Fund study "Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace," shouldn't be taken at face value.

Commonwealth Fund suggests the big news is that employers themselves support an employer mandate. The press release's first paragraph says, "Employers strongly support providing health coverage for their workers, with a majority even backing a mandate that companies either provide such benefits or pay into a fund to cover the uninsured."

The report itself finds, "Among the policy options presented to them, a majority of employers expressed interest in new group insurance options that would require them to make premium contributions for their employees."

Wow! Yikes! A majority of employers support mandatory coverage?! How can that be?

It can't be, and it isn't. The only way Commonwealth Fund was able to get such a result was by limiting the "policy options presented" to two: "Expand public insurance" or "Require employers to offer benefits or contribute to the cost." No other option was available.

This is like giving survey respondents the option of death by hanging or death by drowning, then announcing "56 percent of all people want to die by drowning!"

The truth, of course, is buried back in the data tables, which very few people will bother to read. The Commonwealth Fund survey also found:

- Employers strongly support, and are strongly willing to cooperate with the administration of, tax credits for workers. Eighty-three percent would be willing to "reduce an eligible employee's withholding tax by the amount of a tax credit," and 77 percent would be willing to "collect a tax credit and apply it to an employee's share of their health insurance premium."
- Fifty-three percent of employers who currently offer coverage would support "federal premium assistance to pay 60% - 75% of COBRA."
- Ninety-three percent would be "willing to provide employees with information about applying to Medicaid and CHIP," while 75 percent would be willing to use payroll withholding to make premium contributions to Medicaid/CHIP.
- Eighty-six percent of employers think it is important to "share in the cost of health insurance for employees," either by providing coverage or making a contribution to the costs.

Source: **http://www.cmwf.org/programs/insurance/collins_job-basedinbalance_ib_718.pdf**

HSAs of Little Account: Ginsburg

Paul Ginsburg, president of the Center for Studying Health System Change, has written an article critical of HSAs, titled "Tax-free But of Little Account," for *Modern Healthcare*.

"People are tired of being 'steered' by faceless bureaucrats with suspect motives. They will do their own steering, thank you."

He makes some good points, such as that the IRS prohibition on "stacked" deductibles means a family must incur at least $2,000 in expenses before coverage kicks in, even when only one family member is using services. That was a regulatory mistake dating back to the Clinton-era IRS interpretation of Archer MSAs. It would be better for the family deductible to be a multiple of individual deductibles.

But Ginsburg uses this problem to dismiss the potential of HSAs in the market, preferring instead the tiered co-pay approach many employers have adopted, especially for prescription drugs but increasingly for hospital services as well. He notes "leading-edge employers and insurers are avoiding the use of large deductibles. Instead, they are developing financial incentives to steer patients to efficient providers."

I'm not sure what "leading-edge" means, but the fact is, while tiered co-pays are fairly common for drugs, they are not for hospital and physician services. Only about 5 percent of HMO and PPO enrollees are subject to them, according to Kaiser Family Foundation's most recent survey of employer health plans.

Employers everywhere are increasing deductibles, coinsurance, co-pays, and premium shares for employees. When comparing HSAs to other types of health plans, one must consider the total out-of-pocket obligation, not just deductibles.

Ginsburg ignores a second problem: that any form of tiered co-pay continues to insulate patients from the true cost of the care provided and fails to address the underlying dynamic of a failed system of third-party payment and third-party rationing.

People in the field selling HSAs report the greatest selling point is not whatever savings may accrue, but the increased information and control the plans offer. People are tired of being "steered" by faceless bureaucrats with suspect motives. They will do their own steering, thank you. That is the genie that is being released, and it is not about to get shoved back into the bottle.

Source: **http://www.hschange.org/content/653/**

Survey Predicts Tripling of Enrollment

Certainly one place to find "leading-edge employers" is in the National Business Group on Health (NBGH, formerly the Washington Business Group on Health). They seem to be quite comfortable with, even enthusiastic about, consumer-driven health care.

NBGH recently conducted a survey with the Watson-Wyatt consulting group on employer attitudes and activities in this arena.

The survey finds 32 percent of large employers plan to offer a consumer-driven plan next year, up from the 21 percent currently offering such coverage. The survey also predicts enrollment in such plans will triple in 2004. Seventy-six percent of employers offering consumer-driven plans "said employee enrollment in the first year of the program was either at or above the expected level," according to the press release, with enrollment ranging from 1 percent to 33 percent of eligible employees.

Employers who have not offered consumer-driven plans were asked why. Twenty-nine percent said there isn't enough experience with such plans yet, and 20 percent doubted such plans would effectively manage costs.

Watson-Wyatt spokesman Ted Chien said, "[W]ith the creation of Health Savings Accounts, employers should take the time now to determine whether a consumer-directed health plan is right for their organization. HSAs may be the added ingredient that makes consumer-directed plans right for more organizations."

Over-Charging the Uninsured

Hospital pricing is heating up as one of the key issues in the care of "self-pay" patients, including both the uninsured and those with HSAs. The person who has done the most to bring attention to this issue is K.B. Forbes, one-time spokesman for Steve Forbes.

K.B. Forbes has organized Consejo de Latinos Unidos, a group focusing on uninsured Hispanics, who are often charged for hospital care three and four times as much as anyone with health insurance who does not pay cash. Forbes calls it price-gouging, and he has wrested some concessions from the Tenet hospitals in California. Unfortunately, the hospitals tend to give price breaks only to patients they deem needy, not to others who simply prefer to pay cash.

Forbes' attention now is focused on Florida and the HCA hospitals, which he calls "the worst abuser of price-gouging" in the country. He isn't confining his efforts to for-profit hospitals, but is also tackling the Seventh Day Adventist Florida Hospital and Orlando Regional.

The Florida Hospital Association is fighting back, defending its discounts and also hinting Forbes is part of an insurance industry conspiracy—an odd accusation since he is critical of insurance discounts.

Source: **http://www.orlandoweekly.com/news/story.asp?ID=4031**

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Arbitration: An Alternative to Lawsuits

by Keith Maurer

Few aspects of the health care debate seem to generate more vigorous discussion than the way medical malpractice and other legal disputes are resolved. This is not surprising, because the number of health care lawsuits has grown steadily over the years, and litigation costs have skyrocketed.

Lawsuit-induced premium increases and the costs of resolving legal disputes are passed on to consumers, furthering patient dissatisfaction with America's health care system. The threat of being sued and the costs that accompany such lawsuits are major impediments to quality care. Medical errors are more likely to go unreported by care providers, because the threat of litigation inhibits open discussion of mistakes and errors.

Resolving Disputes

Arbitration can be a better vehicle for resolving health care disputes. Through a pre-dispute arbitration agreement, patients and providers agree to shift future legal disputes out of the lawsuit system into a fair, inexpensive, and more efficient system. Arbitration does not limit a party's right to seek redress but simply shifts the resolution of the dispute to a different forum.

Arbitration is good for both organizations and individuals. In the 1995 *Allied-Bruce Terminix* case, the U.S. Supreme Court noted arbitration's benefits compared to litigation, including less expense, simpler procedural and evidence rules, less hostility between parties, less disruption of ongoing and future dealings among the parties, and more flexible scheduling of times and places for hearings and discovery.

Despite overwhelming support from the judiciary—and empirical evidence that shows arbitration is fair—some have doubted arbitration's benefits, basing their views on long-held myths that individuals do not fare as well in arbitration as they do in court. Still others have attempted to prove arbitration is more costly to individuals than litigation.

These suspicions have not held up under reasonable scrutiny. Individuals are not at a disadvantage in arbitration. A number of commentators and researchers have concluded individuals fare at least as well, if not better, in arbitration than in court.

It is also well-settled that overall legal fees in arbitration are generally much lower than litigation. Courts and commentators who have thoughtfully compared overall litigation costs to overall arbitration costs have repeatedly reached this conclusion.

Federal and State Arbitration Law

Most states have enacted laws to govern arbitration in the health care arena. Many state statutes set out specific requirements for arbitration agreements in health care. The Federal Arbitration Act (FAA), however, preempts state laws that are inconsistent with its guidelines.

The FAA was passed to reverse the courts' bias against arbitration. The Supreme Court has expressly held that the FAA applies to all disputes involving interstate commerce, and that the FAA should be read broadly to require arbitration where the contract contains an arbitration clause. Underlying this policy is Congress's view that arbitration constitutes a more efficient dispute resolution process than litigation. Federal preemption limits the ability of a state to place onerous requirements on arbitration agreements.

"Lawsuit-induced premium increases and the costs of resolving legal disputes are passed on to consumers, furthering patient dissatisfaction with America's health care system."

In *Doctor's Associates v. Casarotto*, the Supreme Court ruled the FAA preempted a Montana statute that placed state requirements on an otherwise-valid arbitration clause. The Montana statute declared an arbitration clause unenforceable unless the clause was printed in a certain format. Subsequently, other courts have interpreted the FAA as preempting state restrictions regarding either the format or the nature of the arbitration agreement.

Courts have determined that activities in the health care industry constitute interstate commerce because shipping medical supplies, performance of certain laboratory tests, and recruitment of physicians often take place across state lines. Therefore, all arbitration agreements in the industry are subject to FAA guidelines.

Legal Precedent

Courts have repeatedly reaffirmed the role of arbitration in all areas of business and consumer transactions, including health care. In *Madden v. Kaiser*

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Foundation Hospitals, the claimant agreed his health plan stipulated that malpractice and all other claims against the hospital would be arbitrated. However, when problems arose, he sued. The California Supreme Court, like courts across the country, dismissed the suit and ordered the claimant to arbitrate the claims.

The *Madden* court listed several benefits of arbitration, including speed and economy, less-strenuous evidence rules, and simplified procedures. The court specifically noted the cost of medical malpractice arbitration would be considerably less than a similar lawsuit.

In *Buraczynski v. Eyring*, the Tennessee Supreme Court held arbitration can be as beneficial in the health care industry as in any other industry. The court also found that "arbitration agreements between physicians and patients are not *per se* void as against public policy."

Elements of Successful Arbitration

Arbitration agreements have been found to be unconscionable when the agreements are not mutual. Courts will refuse to enforce an agreement, for example, that permits a patient to use only arbitration for dispute resolution while the patient's physician can sue in a court of law.

"Arbitration agreements ... can serve as the vehicle toward a more rational, efficient, and cost-effective forum in which to resolve health care disputes."

Courts also will scrutinize a patient's prospective costs to determine whether arbitration is fair or unconscionable. Under appropriate circumstances, a portion of the patient's costs of arbitration must be borne by the health care provider, and in appropriate cases, arbitration must be available without cost to indigent patients. The fee schedules of most major providers of arbitration services, including the National Arbitration Forum (NAF), reflect the guidelines set forth by the courts. The U.S. Supreme Court has recognized the NAF's Code of Procedure as "a model of fair cost and fee allocation."

Arbitration providers should not have affiliation with any party to an arbitration. In *Engalla v. Permanente Medical Group, Inc.*, the California Supreme Court held an arbitration process administered by one of the parties leaves that party open to lawsuits alleging misconduct or misrepresentation related to the process, regardless of the neutrality of the arbitrator.

The real importance of *Engalla*'s remand for fact-finding on "procedural unfairness" or "fraud" is that susceptibility to such collateral lawsuits obviates much of the value of efficient and rational arbitration. The *Engalla* opinion itself makes clear that arbitration administered by independent third parties such as the NAF are immune from these attacks.

Conclusion

Arbitration agreements are welcomed in the health care industry. They can serve as the vehicle toward a more rational, efficient, and cost-effective forum in which to resolve health care disputes. After all, we can't sue our way to better health care.

Keith Maurer is assistant general counsel for the National Arbitration Forum. His email address is **kmaurer@arb-forum.com**.

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For more information visit the Web site of the National Arbitration Forum at **http://www.arb-forum.com**.

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Maine

Continued from page 1

gram, called Dirigo—the state motto and Latin for "I lead." The plan was championed by Governor John Baldacci, a Democrat who campaigned for election on the issue of national health care.

Uninsured Maine residents who elect to enroll in the program will get health coverage through private insurers at rates heavily subsidized by the state and participating employers.

Key questions raised during last year's debate over the program remain unanswered: How much will it cost when fully in place? How many employers will participate? How much will they be required to contribute? And, perhaps most important, can the state pull it off as planned without a broad-based tax increase on individuals or businesses?

The Baldacci administration projects the program will cost roughly $90 million in its first year. Beyond that, the costs are unknown.

W. Tom Sawyer Jr., a Republican state senator from Bangor, has raised other questions, particularly about the program's impact on health care providers and insurers now serving the state. "Will providers accept reimbursement at reduced rates?" he asks. "Will Anthem Blue Cross and Blue Shield remain in the state? Will insurance premiums go up by 4 percent? Can Dirigo Health achieve its goals with an acceptable expense ratio? Will the finest health care in the world now be rationed to reduce costs?"

The program seeks to fill the gaps between private insurance and Medicaid that leave 160,000 persons in Maine uninsured. It aims to enroll 31,000 persons this year. By 2009, all uninsured Maine residents would be given an opportunity to enroll in the program.

Failures Elsewhere

"Making something like this work anywhere is an experiment. And we will all learn in the process," acknowledged Jay Wolfson, professor of public health and medicine at the University of South Florida. Howard Berliner, a health policy professor at New School University in New York City, agreed, noting "No other state currently has as far-reaching a plan as Maine."

Other states have, however, seen efforts similar to Maine's fail badly.

- In Tennessee, Governor Phil Bredesen (D) has had to propose severe benefit cuts and copayments for beneficiaries in the state's out-of-control TennCare program, which was projected to absorb 36 percent of the state budget in 2008. (See "'Last Chance' for TennCare," *Health Care News*, April 2004.)
- In Washington State, a plan similar to Maine's Dirigo is one of the main drivers of a fiscal year 2004 budget deficit of between $60 and $85 billion. According to a 2003 report from the National Conference of State Legislatures, "the new budget includes a number of additional cuts in health care coverage, including elimination of state-funded health coverage for 60,000 low-income childless adults under the state's Basic Health Plan."

In November 2002, voters in Oregon overwhelmingly rejected a single-payer proposal that would have created a state government-run health plan covering 100 percent of Oregonians' "medically necessary" health care costs. (See "Oregon Voters Rebuff Single-Payer Measure," *Health Care News*, December 2002.)

Price Controls

Maine officials expect $52 million in one-time federal money to help cover the program's start-up costs.

Beyond that, the program will be funded on an ongoing basis through the payments made by employers who choose to participate in order to provide health coverage to their workers. The state also projects it can redirect to Dirigo $80 million in cost savings per year—achieved by eliminating un-reimbursed medical costs run up by uninsured people and persuading hospitals and providers to impose price controls on medical services.

The uninsured who are unemployed, or whose employers do not participate in the program, will be required to pay premiums in order to get coverage through Dirigo. State sources were unable to provide *Health Care News* with an estimate of how high those premiums might be. Information developed in 2003 by the state indicates only that premiums will be charged on a sliding scale based on income, with eligibility for the program extended to those earning up to 300 percent of the federal poverty level: $26,000 for a single insured or $55,200 for a family of four.

In addition to launching the new Dirigo program, Maine will open its Medicaid program to cover more poor people. The state also has a prescription drug program, Maine Rx, that requires drug companies to offer discounts on prescription drugs provided to the elderly, working poor, and others.

What Lies Ahead

Richard Batt, president of the Franklin Community Health Network, warned "Maine government cannot create a central control system that will work effectively to make decisions that are so complicated—socially, technologically, and financially—and that matter so much to patients and communities."

He predicted "it will be extraordinarily damaging to health care in Maine if Dirigo Health legislation is passed, goals are not met, and we move towards state government control over rationing of health services, capital, prices, and profits."

Merrill Matthews, director of the Council for Affordable Health Insurance, also warned of potentially dangerous unintended consequences. He told *Health Care News*, "Even though Maine is next to Canada, and gets a lot of business from Canadians coming south of the border to get care they can't get in Canada, the governor and state legislature haven't learned a thing."

With Dirigo Health in place, he predicted, "not only Canadians will be traveling south, but Mainers will be joining them—heading to New Hampshire."

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www.maine.gov/governor/

At a June 18, 2003 ceremony in the backyard of the Blaine House, Governor John Baldacci (at podium, right) signed into law the Dirigo Health plan he championed.

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Carefx, along with its many partners, provides health care organizations clinically oriented software tools and services that answer the need for HIPAA compliancy, streamlining clinician access to patient information, and improving patient safety and security authentication while at the same time working within the customers' current infrastructure and budget requirements. *See our ad on page 6*

DataLoom Solutions
DataLoom Solutions is a leading business intelligence/data analytics provider. Our HealthWeaver® Solution is pre-built and optimized exclusively for the health care industry. It provides powerful industry standard and ad hoc OLAP reporting. By simply "dragging and dropping" data elements, ad hoc reports are created "on the fly" via the Internet or intranet. HealthWeaver® offers an exclusive dashboard that establishes organizational scorecarding, benchmarking, and predictive modeling. *See our ad on page 9*

Disease Management Association of America
DMAA is the only non-profit association representing all stake-holders in the DM community through public and private advocacy targeting the health care industry, government agencies, employers, and the general public to educate them on the important role DM programs play in improving health care quality and outcomes for chronically ill patients. *See our ad on page 2*

Eldorado Computing, Inc.
ECI is an industry-leading supplier of integrated software and ASP solutions for health care payers. Our automated solutions reduce the administrative costs of health benefit management by streamlining all phases of the adjudication process. Our 20 years of experience working closely with the industry's largest payers has enabled us to provide a single, end-to-end benefit processing solution with the most flexibility. *See our ad on page 18*

Health Dialog
Health Dialog is a leading provider of health coaching and data analytic services proven to reduce unwarranted variation in health care. We help individuals develop the confidence, motivation, and skills necessary to manage chronic conditions and make informed medical decisions. Our approach improves physician-patient interactions, increases satisfaction, and reduces medical costs. For more information about Health Dialog, visit us on the Web at www.healthdialog.com or call 1-877-277-5900. *See our ad on page 3*

National Committee for Quality Assurance
NCQA is a private, not-for-profit organization dedicated to improving the quality of health care. The organization's primary activities are assessing and reporting on the quality of the nation's managed care plans, work that has led to partnership efforts with many states, the federal government, employers, consumer groups, and business coalitions. *See our ad on page 16*

Sourcecorp
Sourcecorp is a national provider of business process solutions specializing in mailroom outsourcing, records management, document conversion, and digital Web repositories. We supply innovative customized solutions to information-intensive industries. Among our services are the data capture and management of medical claims and records, insurance forms, credit card applications, state tax forms, and human resources documents. Our applications help industries with a high volume of paper-based transactions capture, convert, organize, store, and retrieve documents. *See our ad on page 18*

TeleTech
TeleTech, a $1 billion leading provider of integrated customer solutions, partners with global clients to develop and execute relevant solutions that enable them to build and grow profitable relationships with their customers. TeleTech has built a global capability supported by 62 customer management centers that employ more than 31,000 professionals spanning North America, Latin America, Asia-Pacific, and Europe. *See our ad on page 15*

Unicomp Corp.
Unicomp's Impower product suite scans paper records, captures digital files, and enables the electronic storage and rapid retrieval of all administrative, financial, and clinical documents. Integrating with all practice management and EMR systems, Impower's imaging and workflow solutions deliver productivity enhancements at all stages of the patient record life cycle, from patient registration through billing follow-up. As an example of workflow improvement, signatures can be electronically captured and securely "sealed" to a digitally displayed document. *See our ad on page 14*

URAC
URAC, an independent, nonprofit organization, is well-known as a leader in promoting health care quality through its accreditation and certification programs. URAC offers a wide range of quality benchmarking programs and services that keep pace with the rapid changes in the health care system, and provide a symbol of excellence for organizations to validate their commitment to quality and accountability. For more information, visit www.urac.org. *See our ad on page 8*

W&F Administration
W&F Administration provides care cost savings on the DME, prosthetics and orthotics, respiratory care, and home infusion services obtained through its national network of 2500 credentialed providers. Savings are achieved through contracted pricing and claims review of the services flowing through the network. As a licensed TPA, we are able to pay claims also. Our approach is unique in that all services we contract for and review are services that we ourselves provide. *See our ad on page 4*

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MY TURN

Kerry's $895 Billion Waffle

During his campaign for the Democratic Party nomination for President, Senator John Kerry (D-Massachusetts) took a narrowly defined position on health care reform, carefully avoiding anything that looked like a re-run of the failed Clinton reform project. Now, with an apparent lock on the nomination, he begins to sound more and more like his Massachusetts colleague, Ted Kennedy.

Another 100-Day Plan

In statements to the media and posted on his campaign Web site (**http://www.johnkerry.com/issues/100days**), Kerry takes an incremental road to national health care, going in the opposite direction of the rapidly growing trend toward consumer-driven care.

In his first 100 days as President, Kerry promises, he would present Congress with what he calls a "realistic plan" to stop spiraling health care costs, insure every child in America, and make it possible for every American to get the same health care as any Member of Congress.

Kenneth Thorpe, health care economics professor at Emory University and former Clinton administration official, estimates the likely cost to taxpayers of the Kerry plan would be $895 billion over 10 years. There is roughly $230 billion in the Kerry proposal to subsidize reimbursements for employers with health insurance plans, and $665 billion for programs targeted at people without insurance.

Kerry's campaign commercials deny the plan would cost $900 billion. But in a March interview on The NewsHour with Jim Lehrer, PBS reporter Margaret Warner said to Kerry, "your plan totaled, as scored by an independent authority [Kenneth Thorpe], $900 billion over 10 years." Kerry responded, "Yes."

Kerry has said he will pay for his 100-day health care plan by repealing the Bush tax cuts only for Americans with annual incomes more than $200,000. IRS data show that move would bring in only $250 billion over 10 years—about $650 billion less than Kerry needs. To fully fund his plan would require that Kerry repeal the Bush tax cuts in their entirety, leading to a tax increase for all Americans—a prospect Kerry has yet to admit.

Liberal Waffles

Following Kennedy's lead, Kerry has dusted off the old liberal goal of forcing all employers to provide health insurance. Kerry focuses on the employer mandate for political reasons, not health care reasons. He wants the labor union vote ... and labor wants at least employer mandates, and ideally single-payer health care.

Kerry would increase taxpayer-funded corporate welfare by reimbursing health plans 75 percent of the catastrophic costs above $50,000. This cost will be shifted to taxpayers and create an incentive to dump high-cost employees onto subsidized taxpayer health insurance. This is more waffle. Kerry has said in the past he wants to reduce corporate welfare.

Another waffle: Kerry says he supports expanding the Federal Employees Health Benefits Program (FEHB) to private citizens ... yet he sides with fellow Democrats seeking to amend the Medicare Prescription Drug, Improvement and Modernization Act of 2003 because it begins the process of extending the FEHB to private citizens on Medicare.

Kerry also seeks to extend eligibility in the State Children's Health Insurance Plan (SCHIP) to young adults age 24 or under. Expansion of this entitlement is pure pandering—an effort to get the youth vote by offering free health insurance at taxpayer expense.

Analyze This

While Kerry appears to come down on both sides of the health care issue at the same time, his voting record clearly defines the man.

According to a summary by the *Congressional Quarterly*, Kerry voted in lockstep with Kennedy in each of 10 years between 1985 and 2001. Over the course of his career, Kerry has sided with Kennedy 94 percent of the time when key votes were taken on Kennedy's favorite cause: national health care.

Kerry has supported the Patient Bill of Rights, mental health parity, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, to name a few. Each of those measures imposes or would impose significant unfunded regulatory and procedural mandates on health care providers and the health insurance industry. Research has proven such mandates increase overall health care costs and health insurance premiums, which in turn fuels the uninsured rate.

You can flip it and you can flop it, but you can't hide Kerry's waffle. His voting record indicates Kerry would pass more of the very legislation that has contributed to the nation's health care angst.

Conrad F. Meier is managing editor of Health Care News. *His email address is* **meier@heartland.org**.

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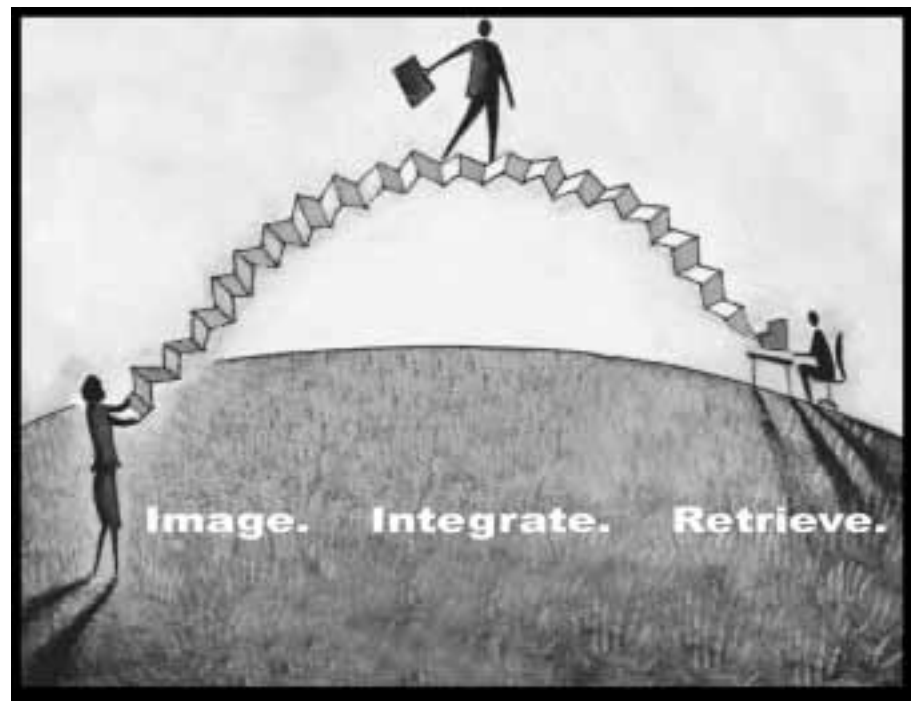

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